INDEPENDENT MEDICAL EXAMINER APPLICATION FOR APPOINTMENT

NEBRASKA WORKERS' COMPENSATION COURT
STATE CAPITOL BUILDING
P.O. BOX 98908
LINCOLN, NE 68509-8908

Applicant's Name		Social Security Number
Address		City or Town
State	Zip Code	Business Phone

EDUCATION AND TRAINING

Name & Location	Dates From To	Major	Degree	Month/Year of degree
College/University				
Medical School				
Osteopathic School				
Chiropractic School				
Other				

PROFESSION

Specialty	Subspecialty
Type of practice	How many years in practice?

Location of practice (include multiple sites if applicable)

Please list any experience or education concerning workers' compensation principles or the Nebraska workers' compensation system.

Have you ever performed an Independent Medical Exam? Yes ☐ No ☐ If yes, how many years have you been performing IME's? _____

What percentage of current practice is IME's?	List any IME training you have attended.

If appointed, what type of cases would you prefer be referred to you?

Please identify any employer, insurer, attorney, employee group, managed care plan or representatives of any of these to whom you are under contract or who regularly use your services.

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Nebraska State License # _____ Tax I.D. # _____ Drug Enforcement Agency # _____

List any other registrations, certifications or licenses you possess (include board certification or board eligibility):

_____

_____

WORK HISTORY

Present Employer	Telephone #:	From _____
Address		Supervisor's Name:
Your Title		

Hospital affiliated with: Hospital #1	Telephone #:	From _____ To _____
Address		Supervisor's Name:
Your Title		

Hospital #2	Telephone #:	From _____ To _____
Address		Supervisor's Name:
Your Title		

Hospital #3	Telephone #:	From _____ To _____
Address		Supervisor's Name:
Your Title		

I request appointment to the list of Independent Medical Examiners maintained by the Nebraska Workers' Compensation Court. I will provide independent, impartial and objective medical findings in all cases that come before me. I will decline a request to serve as an independent medical examiner only for good cause shown. I will conduct an examination, if necessary, within twenty-eight calendar days from notification of assignment. I will submit a written report within seven calendar days following receipt of all necessary records and information, the completion of an examination, or the completion of any required tests, whichever is applicable. I will accept the fees established pursuant to Rule 65 as payment in full for services rendered as an independent medical examiner. I will submit to a review pursuant to Rule 62,E.

I have read and understand Rule 62 through Rule 66 of the Nebraska Workers' Compensation Court which describe the independent medical examiner system. I agree to comply with all of the provisions of these rules.

I hereby attest that the information contained in this application is correct to the best of my knowledge and belief. I understand that false or misleading information may result in the rejection of my application or in my removal from the list if I am appointed.

_____ _____

SIGNATURE DATE